DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAID PURCHASING ADMINISTRATION
Olympia, Washington

To:	Outpatient Hospitals Managed Care Organizations	**# Memo : 11-14** **Issued:** March 31, 2011
From:	Doug Porter, Administrator and Medicaid Director Health Care Authority/Medicaid Purchasing Administration	**For information, contact:** 1-800-562-3022 or go to: http://hrsa.dshs.wa.gov/contact/default.aspx

Subject: **Outpatient Hospital Services: Fee Schedule and Authorization Changes, Limits for Outpatient Rehabilitation, Enforcement of NUBC Requirements, and Clarification Maximum Unit Limitations**

Effective for dates of service on and after April 1, 2011, the Department of Social and Health Services (the Department) will:

- Update the *Outpatient Hospital and Outpatient Prospective Payment System (OPPS) Fee Schedule* with added codes and coverage changes;
- Change in prior authorization requirements for certain Current Procedural Terminology Codes;
- Add new limits for outpatient rehabilitation;
- Enforce National Uniform Billing Committee (NUBC) coding requirements for emergency room (ER) claims; and
- Clarify maximum unit limitations for outpatient hospital claims.

Overview

All policies previously published remain the same unless specifically identified as changed in this memo.

Fee Schedule Changes

Added/Changed Procedure Codes

Effective for dates of service on and after April 1, 2011, the Department will update the *Outpatient Hospital and Outpatient Prospective Payment System (OPPS) Fee Schedule* for procedures performed in an outpatient hospital setting.

Effective for dates of service on and after April 1, **2011**, the Department will add the following Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) procedure codes to the OPPS fee schedule when performed in an outpatient setting. Procedures with a value in the APC column may be paid using that method if an APC payment is not applicable. Where no method is listed, the RCC method may be used if APC payment is not applicable.

Procedure Code	Brief Description	Coverage Indicator	Max Units	Alternate Payment Method
C9280	Injection, eribulin mesylate	1	UR	RCC
C9281	Injection, pegloticase	0	N	
C9282	Inj, ceftaroline fosamil	1	UR	RCC
C9729	Percut lumbar lami	0	N	
Q2040	Incobotulinumtoxin A	0	N	

Effective for dates of service on and after April 1, 2011, the Department will change the following procedure codes **from noncovered to covered**. Procedures with a value in the APC column may be paid using that method if an APC payment is not applicable. Where no method is listed, the RCC method may be used if APC payment is not applicable.

Prior Authorization Requirement	Procedure Code	Brief Description	Coverage Indicator	Max Units	Alternate Payment Method
PA	J0775	Collagenase, clost hist inj	1	UR	RCC
	J0882	Darbepoetin alfa, esrd use	1	UR	Max Fee

Effective for dates of service on and after April 1, 2011, the Department will change the following procedure codes **from covered to noncovered**.

Procedure Code	Brief Description
99406	Behav chng smoking 3-10 min*
99407	Behav chng smoking > 10 min

*Smoking cessation services are still covered. See Section B of the current *Physician-Related Services/Healthcare Professional Services Billing Instructions* for Smoking Cessation policy.

Authorization Requirement Changes

Effective for dates of service on and after April 1, 2011, the Department will no longer require prior authorization (PA) for the following Current Procedural Terminology (CPT®) codes:

Procedure Code	Brief Description
J1290	Ecallantide injection

Effective for dates of service on and after July 1, 2011, the Department will require prior authorization (PA) for the following Current Procedural Terminology (CPT®) codes:

Procedure Code	Brief Description	Prior Authorization
J1745	Infiximab injection*	PA

*See *Physician-Related Services/Healthcare Professional Services Billing Instructions* for details.

Outpatient Rehabilitation (Therapy) Benefits

Effective for dates of service on and after April 1, 2011, the following are the new benefit limits for outpatient rehabilitation (formerly occupational therapy, physical therapy, and speech therapy) for clients 21 years of age and older.

Therapy	Benefit Limit
Physical therapy	24 units (equals approximately 6 hours);
Occupational therapy	24 units (equals approximately 6 hours);
Speech therapy	6 units (equals a total of 6 untimed visits)

These benefit limits are **per client**, **per calendar year** and are ***in addition*** to:

- One evaluation; and
- One re-evaluation at time of discharge for each therapy type. Authorization is not required.

Services Provided in an Outpatient Hospital or Hospital-Based Clinic Setting

- Physical, occupational, and speech therapists may not provide services in an outpatient hospital or hospital based clinic setting unless the therapist is a member of the hospital staff.

- The Department does not pay a facility fee for rehabilitation services.

- When services are provided in a hospital or hospital based clinic setting, payment is made to the hospital. A single claim may be submitted by the hospital, on a UB-04 claim form or an equivalent electronic transaction, consistent with facility billing guidelines. A concurrent professional claim is not appropriate.

- Payments to the hospital are considered payment in full.

When billing the Department, hospitals must use the appropriate:

1. Revenue code;
2. CPT code;
3. Modifiers; and
4. Modality.

Modality	Revenue Code	Modifier
Physical Therapy	042X	GP
Occupational Therapy	043X	GO
Speech Therapy	044X	GN

See the Department's new *Outpatient Rehabilitation Billing Instructions* and # Memo 11-12 for detailed information on scope and limitations of this program.

Enforcement of Coding Requirements for Emergency Room Claims

Effective for dates of service on and after April 1, 2011, the Department will enforce the National Uniform Billing Committee (NUBC) requirement to report a valid ICD-9 **reason for visit** diagnosis code on unscheduled outpatient hospital service claims. This corresponds to claims with 045X, 0516, 0526 revenue codes. Failure to report a reason for visit may result in denial of payment.

Maximum Unit Limitations

Maximum unit limitations for individual procedure codes are specified in the *Outpatient Prospective Payment System (OPPS) and Outpatient Hospitals Fee Schedule*. Unit limits apply to all facilities making outpatient claims on UB-04 claim forms or as equivalent electronic transactions, including Critical Access Hospitals (CAH). The Department does not cover claimed units that exceed the limits. The Department will evenly divide the claimed charges by the claimed units to establish the per-unit billed charge.

The Department also adheres to National Correct Coding Initiative (NCCI) standards. These standards are enforced by Centers for Medicare and Medicaid Services (CMS) edits and may impose additional unit limitations not specified in the Outpatient Hospital Fee Schedule.

Providers concerned that maximum unit limits are below the levels at which a service is commonly applied are encouraged to contact the Department's Medical Benefits and Clinical Review group by writing to:

Medicaid Purchasing Administration
Division of Healthcare Services
ATTN: Max Units
P.O. Box 45506
Olympia, WA 98504-5506.

How Can I Get the Department/MPA Provider Documents?

To download and print the Department/MPA provider numbered memos and billing instructions, go to the Department/MPA website at: http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).